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ABSTRACT

This handbook for attorneys represents part of an effort to improve legal representation for criminal defendants with mental illness. The handbook was developed and reviewed by both mental health professionals and attorneys experienced in criminal and mental health law. However, it is not a comprehensive guide on mental health law or on how to represent a defendant with mental illness. It does not address the law as it relates to juvenile defendants with mental illness. It is designed to give attorneys a starting point for their work with their adult clients who have a mental illness, to alert them to some basic legal options that may want to consider, and to give them some ideas about where to go for assistance. (GCP)

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MENTAL ILLNESS, YOUR CLIENT AND THE CRIMINAL LAW

A Handbook for Attorneys
Who Represent Persons With Mental Illness

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Texas Appleseed Mission

Texas Appleseed's mission is to promote justice for all Texans by working to give a voice to individuals and groups that are otherwise overlooked in the legal process. Texas Appleseed has worked on some of the state's most pressing problems. Our work to improve the rights of poor people in the criminal justice system alerted us to the special needs of defendants with mental illness and the inadequate representation they sometimes receive. We hope this handbook will help attorneys better represent their clients with mental illness in the criminal justice system.

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MENTAL ILLNESS, YOUR CLIENT, AND THE CRIMINAL LAW:

A HANDBOOK FOR ATTORNEYS WHO REPRESENT PERSONS WITH MENTAL ILLNESS

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About This Handbook

Texas Appleseed issued its *Fair Defense Report: Analysis of Indigent Defense Practices in Texas* more than one year ago. Our work to assess the condition of indigent persons in the criminal justice system revealed the special needs of defendants with mental illness and the inadequate representation they sometimes receive. Defense attorneys, like other court officials, often fail to recognize mental illness. Even when clients are recognized as mentally ill, the *Fair Defense Report* revealed that many attorneys are not familiar with the specialized mechanisms, procedures, and laws that apply to persons with mental illness. For instance, many attorneys are unfamiliar with competence statutes and procedures. This lack of knowledge, together with concerns about the time and expense of conducting competence evaluations, the paucity of qualified competence evaluators, the lack of impartiality and independence of examining doctors, and often, the client's desire to get out of jail quickly, may result in a client entering a plea to an alleged offense when he or she is not competent to do so. When mental incapacity reduces the defendant's ability to understand what is happening to him or her or to participate in his or her own defense, the basic fairness of the criminal trial process is threatened.

The *Fair Defense Report* revealed many other shortcomings in the treatment and representation of mentally ill defendants. With the exception of death penalty cases, mental health experts are rarely, if ever, requested or appointed in areas other than competence issues. Attorneys' lack of expertise in finding, evaluating, and questioning experts and the lack of credible and impartial experts, means that such experts are not being used to represent defendants in critical areas such as mitigation and sentencing work. The general lack of understanding of mental illness and treatment options contributes significantly to harsher sentences, longer stays in jail, and frequent revocations of probation for defendants with mental illness.

As part of Appleseed's ongoing efforts to improve legal representation for criminal defendants with mental illness, we have drafted this handbook for attorneys. This handbook was developed and reviewed by both mental health professionals and attorneys experienced in criminal and mental health law. However, it is not a comprehensive guide on mental health law or on how to represent a defendant with mental illness. It does not address the law as it relates to juvenile defendants with mental illness. It is designed to give attorneys a starting point for their work with their adult clients who have a mental illness, to alert them to some basic legal options they may want to consider, and to give them some ideas about where to go for assistance.

We hope this handbook encourages attorneys who represent defendants with mental illness to go the extra mile for their clients. It could make all the difference.

Top Ten Things To Keep In Mind As You Represent A Client With Mental Illness

1. MENTAL ILLNESS AND MENTAL RETARDATION ARE NOT THE SAME: Mental retardation is a permanent condition characterized by significantly below average intelligence accompanied by significant limitations in certain skill areas. Mental illness, on the other hand, usually involves disturbances in thought processes and emotions and may be temporary, cyclical, or episodic. Most people with mental illness do not have intellectual deficits; some, in fact, have high intelligence. It is possible for a person with mental retardation to also have a mental illness. Many of the Texas statutes that address mental illness also address mental retardation, and you should look carefully at those statutes for the differences in how the two are addressed. This handbook does not address mental retardation.

2. YOU OWE YOUR CLIENT A ZEALOUS REPRESENTATION: You have the ethical obligation to zealously represent your client, which may include exploring your client's case for mental health issues. It may also include bringing appropriate motions if your client's mental illness has affected his or her case in any of the ways discussed in Section I of this handbook.

3. IF YOUR CLIENT IS INCOMPETENT, STOP AND ORDER AN EVALUATION: If your client is incompetent, he or she may not be able to make informed decisions about fundamental issues, such as whether or not to enter into a plea bargain agreement or, instead, proceed to trial. Do not allow your client to accept a plea bargain, or make any other decisions regarding the case, when you have reason to believe that he or she is incompetent. Instead, immediately request a competence evaluation.

4. MENTAL ILLNESS AND INCOMPETENCE ARE NOT SYNONYMOUS–AND YOU SHOULD BE CONCERNED ABOUT BOTH: Keep in mind that competence to stand trial is distinct from mental illness, so that some clients who are fit to proceed to trial may still have serious mental illness. Even if your client does not have a competence issue, there may still be significant mental health issues in the case that you should explore. Remember, however, that if your client is competent to stand trial, he or she makes the final decision about how to proceed with the case, whether or not to explore mental health issues, and whether treatment should be part of a disposition.

5. AN INSANITY DEFENSE MAY BE APPROPRIATE: By taking the time to properly inquire about your client's mental illness and to explore various legal and medical options, you may obtain information that will help you decide if you should explore an insanity defense. If your client receives a not guilty by reason of insanity verdict, he or she will avoid receiving an unjust conviction. However, as discussed further in Section VII of this handbook, there may be disadvantages to pursuing the insanity defense and you should discuss all of the pros and cons with your client.

6. MITIGATE, MITIGATE, MITIGATE: Mental conditions that inspire compassion, without justifying or excusing the crime, can be powerful mitigation evidence. Part of your job as an attorney is to present the judge or jury with evidence that reveals your client as someone with significant impairments and disabilities that limit his or her reasoning or judgment. Mitigation evidence can be used to argue for a shorter term of incarceration or for probation instead of incarceration. In capital cases, mental illness and mental health testimony may mean the difference between life and death.

7. INEFFECTIVE ASSISTANCE OF COUNSEL AND REVERSIBLE ERROR: An attorney's failure to request the appointment or otherwise obtain the assistance of qualified mental health or mental rehabilitation professionals when indicated can be a violation of a defendant's Sixth Amendment right to effective assistance of counsel. This certainly applies to capital cases but also other homicide cases and any alleged offense that suggests mental aberration. A defendant's prior history of mental impairment may indicate that you need the assistance of a professional evaluation. An appellate judge may find reversible error if a client is truly incompetent or insane and the issue is not raised in court.

8. OVERCOME YOUR OWN PREJUDICES BEFORE YOU HURT YOUR CLIENT AND HIS OR HER CASE: A popular assumption is that mental-state defenses are attempts by bad persons to "get off" or deny responsibility for their behavior. Many people believe that persons with mental illness, by contrast to those with mental retardation, have the ability to fully appreciate the nature of their acts and control them. This denial of psychiatric disability can deeply influence the attitudes of both judges and juries toward expert witnesses and mental health defenses. Part of your job, if you are representing a person with mental illness, is to overcome cynicism toward mental health issues in criminal cases. Mental illness is brain disease. It is medical illness, not "hocus pocus," and the people who experience it suffer profoundly. Mental illness can be diagnosed, treated, and sometimes even cured. You do your client a disservice by representing it any other way.

9. INCARCERATION IS PARTICULARLY HARMFUL TO PEOPLE WITH MENTAL ILLNESS: Jails can be very damaging to the stability, mental health, and physical health of people with mental illness. Numerous studies show that placing mentally ill people in single cells, isolation, or "lock down" can worsen their schizophrenia, depression, and anxiety. Mentally ill and mentally retarded adults are also more likely than others to be victimized by other inmates or jail staff. They are at high risk for suicide. They generally get inadequate, if any, medication and treatment while in jail. As set out in section V of this handbook, you should seek to get your client's case dismissed quickly and, if appropriate, try to get your client released on bond.

10. DO NOT LET YOUR CLIENT GET CAUGHT IN THE "REVOLVING DOOR": Many adults with mental illness are arrested for minor offenses that directly relate to their illness, their poverty, or their disturbed behavior. They cycle repeatedly through the courts and jails, charged with the same petty offenses. This "revolving door" is not only a burden to the courts and the criminal justice system, but it is costly to society, to these individuals, and to their families. By quickly pleading your client to "time served" without exploring his or her mental illness, you may lose the opportunity to help your client get better so that he or she does not re-offend. Attorneys should do their best to link mentally ill defendants to appropriate treatment or services that will help them keep out of trouble. While it is important to get your client out of jail as soon as possible, it is equally important to keep him or her from returning to jail. Releasing persons with mental illness back into the community with no plan for treatment or aftercare is a recipe for revocation and recidivism. Don't set up your client to fail.

SECTION 1

WHAT IS MENTAL ILLNESS AND WHY SHOULD YOU CARE?

WHAT IS MENTAL ILLNESS?

Article 571.003(14) of the Texas Health and Safety Code (also called the Mental Health Code) defines mental illness as "an illness, disease, or condition, other than epilepsy, senility, alcoholism, or mental deficiency, that:

(A) substantially impairs a person's thought, perception of reality, emotional process, or judgment; or
(B) grossly impairs behavior as demonstrated by recent disturbed behavior."

Many of the pertinent criminal statutes include cross-reference to this definition.

Mental disorders are quite common. In fact, one in five Americans has some type of mental disorder in any given year. About 15% of all people with mental illness will have an accompanying substance abuse disorder, although the percentage in the criminal justice system is much higher. About 16-20% of the jail and prison population has a significant mental illness (schizophrenia, bipolar disorder, or major depression) at any given time; this far exceeds the rate for these disorders in the general population. There is a myth that persons with severe mental illness are significantly more violent than other people. Research shows this is not true. In fact, the vast majority of persons with mental illness in jail are arrested for nonviolent offenses. Often, it is when people with mental illness are undiagnosed and untreated or when they stop taking their medication that they get in trouble with the law.

SERIOUS MENTAL ILLNESSES

There are a variety of mental illnesses and their severity ranges from mild to life-threatening. Many serious mental illnesses, such as those listed below, are chronic in nature, but can be managed or ameliorated with the proper medication and treatment.

Schizophrenia is a mental disorder that impairs a person's ability to think, make judgments, respond emotionally, remember, communicate, interpret reality, and/or behave appropriately so as to grossly interfere with the person's capacity to meet the ordinary demands of life. Symptoms may include poor reasoning, disconnected and confusing language, hallucinations, delusions, and deterioration of appearance and personal hygiene.

Bipolar disorder or manic-depressive illness is characterized by a person's moods, altering between two extremes of depression and mania (exaggerated excitement). The manic phase of bipolar disorder is often accompanied by delusions, irritability, rapid speech, and increased activity.

Major depression is much more severe than the depression that most of us feel on occasion. People suffering from major depression may completely lose their interest in daily activities, feel unable to go about daily tasks, have difficulty sleeping, be unable to concentrate, have feelings of worthlessness, guilt, and hopelessness, and may have suicidal thoughts.

Other mental disorders or mental illnesses are defined in the glossary at the end of this handbook. While less severe than the disorders mentioned above, many of these disorders are also disabling and can profoundly affect the way a person thinks, behaves, and relates to other people. As an attorney, you can help ensure the fair, efficient, and humane administration of justice by paying special attention to those defendants who have mental illness.

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WHY SHOULD YOU CARE IF YOUR CLIENT HAS A MENTAL ILLNESS?

Your client's mental illness may affect various aspects of his or her case, such as:

- the vountariness of your client's statements. Statements that are the product of mental illness or mental retardation will not be excluded from evidence in the absence of impermissible coercive official conduct. However, conduct that is not coercive when used with nondisabled persons may impair the voluntariness of the statements of persons who are mentally ill;

- your client's ability to understand the rights explained to him or her, including Miranda rights;

- the reliability of your client's statements;

- your client's memory, ability to make decisions, reasoning, judgment, volition, and comprehension;

- your client's ability to understand cause and consequence or learn from prior mistakes;

- the ability of your client to waive rights in a knowing, intelligent, and voluntary manner, including the right to counsel, right to be present, right to trial and appeal, and right to testify; and

- the ability of your client to meaningfully participate in trial preparation and at trial.

SECTION 2
THE FAIR DEFENSE ACT

HOW DOES THE FAIR DEFENSE ACT AFFECT YOU?

The Fair Defense Act became effective on January 1, 2002 and, among other things, it imposes new obligations on attorneys who represent indigent defendants in Texas. When you have been appointed to represent a client, you must make every reasonable effort to:

- contact your client by the end of the first working day after the date on which you were appointed, and
- interview your client as soon as practicable after you have been appointed.

Once you have been appointed, you must represent your client through the final disposition of your client's case, including any appeals, or until you are replaced by other counsel after a finding of good cause has been entered on the record. It may be the case in many counties that if a defendant wishes to appeal his or her case, you will be replaced by another attorney who has met specific requirements to handle appeals, and that your responsibility will end once all post-trial motions have been filed. If you have any questions about when your representation of your client ends, you should contact the county's appointing authority.

HOW DOES THE FAIR DEFENSE ACT HELP MENTALLY ILL DEFENDANTS?

Besides requiring that attorneys contact their clients quickly, the Fair Defense Act mandates that each county in Texas set out objective standards that each attorney in that county must meet before qualifying to represent indigent defendants. Some counties may require that attorneys who wish to represent mentally ill defendants meet specific requirements to do so. These provisions will be particularly critical to those indigent defendants who are mentally ill. As set out above, jail can be especially threatening to mentally ill defendants. Thus, the sooner a client is interviewed by specially qualified counsel, the sooner that attorney will know if the client has a mental illness, and the sooner the attorney will be able to develop a strategy for getting the client out of jail and, if necessary, into treatment.

The Fair Defense Act also creates the Task Force on Indigent Defense, which is required to develop standards and policies to advance the quality of representation for indigent defendants in Texas. The Act suggests certain issues the Task Force may want to specifically consider in its development of these policies and standards, and one of these issues concerns the qualification standards "appropriate for representation of mentally ill defendants." The Act thus contemplates specific standards that all attorneys in Texas must meet if they want to be appointed to represent mentally ill defendants.

Finally, the Fair Defense Act provides for the reimbursement of reasonable and necessary expenses, including mental health and other experts.

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SECTION 3
THE INITIAL INTERVIEW

HOW CAN YOU TELL IF YOUR CLIENT HAS A MENTAL ILLNESS?

Here are some things you should look for when trying to spot a mental illness:

Certain types of offenses. Offenses such as criminal mischief, criminal trespass, prostitution, failure to identify, and public intoxication may signal an underlying mental illness. Many mentally ill defendants are also brought in on charges of "assault of a public servant" because they tangle with police while they are psychotic. These offenses are frequently related to the client's poverty, homelessness, substance abuse, or transient lifestyle, but if they are part of your client's offense history or if your client has been arrested several times for the same offense, he or she may have a mental illness.

Behavioral or physiological clues. Your client may exhibit rapid eye blinking, vacant stares, tics or tremors, or unusual facial expressions. The symptoms of a mental illness and the medications your client may be taking may make him or her appear slow, inattentive, or sluggish. Your client may exhibit psychomotor retardation (slow reactions in movements or in answering questions) or clumsiness. Your client may be excessively uncooperative. On the other hand, your client may appear very agitated, tense, or hypervigilant.

Circular nature of your client's conversation. While talking with your client, you may note the lack of a logical train of thought. In other words, your client may be unable to get from point A to point B.

Use of mental health terms. If your client has been in treatment, he or she may talk about his or her counselor or caseworker, about various medications, or about being treated in a hospital. He or she may use terms such as some of those listed in the glossary.

Paranoid statements. Your client may make paranoid statements or accusations. Or, he or she may exhibit phobias or irrational fears, such as fear of leaving the jail cell.

Reality confusion. Your client may exhibit hallucinations. He or she may hear voices, see things, have illusions, or misperceive a harmless image as threatening. Your client may be disoriented and seem confused about people and surroundings. He or she may have delusions (consistent false beliefs), such as lawyers who are out to get him or her, guards in love with him or her, or your client may believe that his or her food has been poisoned.

Speech and language problems. Your client may exhibit language difficulties, including incoherence, nonsensical speech, the use of made-up language, and non sequiturs. Your client may change the subject in mid-sentence, speak tangentially, or persistently repeat himself or herself. Or, instead, he or she may exhibit rapid, racing speech, or give monosyllabic or lengthy, empty answers. Your client may be easily distracted or may substitute inappropriate words for other words.

Memory and attention issues. Your client may exhibit a limited attention span, selective inattention on emotionally charged issues, or amnesia. These may also be signs that your client has had a head injury.

Inappropriate emotional tone. Your client may exhibit emotions such as anxiety, suspicion, hostility, irritability, excitement; or he or she may appear downcast and depressed. On the other hand, your client may express little emotion at all or appear to have flat affect. Your client may exhibit emotional instability. If your client has a bipolar disorder (manic-depression), he or she may talk in a very rapid manner, seem excited, laugh at inappropriate times, make grandiose statements, or be very irritable.

Personal insight and problem-solving difficulties. Your client may exhibit self-esteem that seems either too high or too low. He or she may get easily frustrated or deny that he or she has mental problems. It may be difficult for your client to make plans and change plans when necessary. Perhaps most important, your client may also have an impaired ability to learn from his or her mistakes.

Unusual social interactions. Your client may have problems relating to others, including isolation, estrangement, difficulty perceiving social cues, suggestibility, emotional withdrawal, a lack of inhibition, and strained relations with family members and friends.

Medical symptoms and complaints. Finally, you should always be alert for physical symptoms, including hypochondria, self-mutilation, accident-proneness, insomnia, hypersomnia, blurred vision, hearing problems, headaches, dizziness, nausea, and loss of control of bodily functions. Some of these problems can develop as a result of incarceration, but many point to other more serious or long-standing mental health problems.

WHAT DO YOU DO IF YOU SUSPECT YOUR CLIENT HAS A MENTAL ILLNESS?

If you have any indication that your client may be incompetent and/or mentally ill, you should explore further. Many people want to hide their mental illness. In fact, many defendants may go to great lengths to hide any indications that they are mentally ill, especially if they are in a jail setting. They may fear being committed to a mental hospital or being forced to take medication. They may not want to admit that they have not been compliant with their treatment–or they just may not want to appear different or dependent in any way for fear of being victimized by others in jail. Just as a person who cannot read will often mask that inability, so too can a person with mental illness learn to hide his or her illness.

Still other clients, particularly if they have never been formally diagnosed or treated, may not understand that they are mentally ill. The stress of the jail environment has been known to bring on symptoms of a person's illness and contribute to his or her deterioration, sometimes to the point of rendering him or her incompetent.

If your client is willing to talk about his or her mental health history and treatment, ask questions such as:

- Have you ever been treated for a mental or emotional problem?
- Have you ever been treated for substance abuse?
- Are you currently receiving treatment? If so, with whom?
- Do you know your diagnosis?
- What types of medication are you taking? Have you taken medications in the past?
- Have you ever been hospitalized for a mental health problem? If so, when and where?
- Are there doctors, friends, or family members I can talk with who are familiar with your treatment?

Be familiar with the names of public mental health clinics in your area (such as MHMR), state mental hospitals (e.g., Vernon, Terrell, and Rusk), and psychiatric prison units (e.g., Skyview, Montford, and Beto). It may be helpful to ask specifically, for example: "Have you been to Vernon or Terrell? Do you go to MHMR? Were you ever at Skyview?"

Be delicate, tactful, and resourceful in your questioning when you sense that your client may not be forthcoming with you.

Mental illness still carries a powerful stigma, especially among males and among people of certain cultures. Blunt questions like "do you have a mental illness?" will not work. Here are some questions you might ask your client instead:

- Are you on any medications and, if so, what are they?
- Have you had any previous medical treatment and, if so, what was it?
- Do you have a juvenile record and, if so, for what types of offenses?
- Were you in any special classes in school and, if so, do you know why?
- Do you receive disability or Supplemental Security Income (SSI) benefits?
- Have you ever felt depressed?
- Have you ever been a patient at the Veterans' Administration (VA)?
- Have you ever been hospitalized?
- Have you ever had any dealings with Mental Health and Mental Retardation (MHMR)?
- Are there doctors, friends, or family members I can talk with about your case?

Remember to speak simply and be prepared to repeat some of what you are saying. Ask simple, open-ended questions. Use eye contact to keep control of the dialogue and to keep your client focused. Do not impose on your client's "personal space." Tell your client when you do not understand and need more information. Paraphrase your client's responses to let him or her know that you understand. Remember that your client's delusions are real to him or her. Do not minimize or try to explain away hallucinations or delusions.

Be patient. If your client has a mental illness, he or she may be irritated, belligerent, or see you as a threat. If your client is out of control, he or she may have a mental disorder. Some of your client's actions, reactions, and mannerisms may be irritating and/or offensive. Do not take this conduct personally; your client's mental illness may be influencing his or her personality. Find out if your client has stopped taking medication. If you can get your client to start taking his or her medication again, it will likely make your experience with him or her more pleasant.

Encourage your client to be honest and forthcoming with you. Tell your client that hiding important medical or mental health information may hurt his or her case and may hinder your ability to represent him or her well.

Do not speak about mental illness in a disparaging or derogatory manner. Do not add to your client's feelings of helplessness, embarrassment, or shame about his or her mental illness. If you believe your client is incompetent, you should still address him or her as if he or she is competent. Many clients who get better after treatment remember how you treated them and what you said to them before treatment. If your client feels that you have treated him or her with respect, you are more likely to forge a trusting relationship with your client, which will help you represent him or her better.

Do not worry about malingering. It is the mental health evaluator's role, not yours, to determine who might be faking mental illness. While it is true that some defendants try to fake mental illness in order to avoid prosecution or to get a reduced sentence, defendants who actually have a mental illness often try to hide their condition.

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SECTION 4

HELPFUL HINTS TO OBTAIN INFORMATION

If after the initial interview with your client you strongly suspect that your client may be mentally ill and/or incompetent, it is good practice to explore the issue further.

WHERE DO YOU LOOK FOR MORE MENTAL HEALTH INFORMATION?

Listed below are some steps you can take to gather relevant information if you suspect your client has a mental illness. Of course, it is always good to speak to your client first about the matter and to get him or her to sign a medical records release form.

- **Call your client's family.** The family is often the best, most current source of information about mental health treatment and history. Family members can also connect you with treatment professionals.
- **Talk informally with jail staff.** Do they report bizarre behavior or complaints from other inmates about your client?
- **Find out where your client is housed in the jail facility.** Many jails have special mental health or observation cells. These may be designated on your client's file or on a county computer screen.
- **Every jail in Texas is required to perform a very basic mental health screening at jail intake**. Get a copy of the form filled out about your client.
- **If a mental health evaluation has been conducted pursuant to the Texas Code of Criminal Procedure, art. 16.22, you should receive a copy of the mental health expert's report**. You should know that the prosecutor also receives a copy of this report. The assessment is solely for purposes of assuring the provision of mental health services, but you may be able to use it to help get the charges against your client dismissed, help get your client diverted to a mental health facility, or help your client secure release on personal bond.
- **If your client is being treated while in jail or is housed in a special cell, serve a Request for Medical Information on jail staff**. Usually jail staff has some information on persons in the jail who exhibit mental illness or take medications.
- **Look at the police report for any indication of mental illness or bizarre behavior** by your client at the time of arrest.
- **If your client is being charged with a probation violation, ask your client's probation officer if your client has a history of mental illness** or is currently on a specialized probation caseload.
- **If your client has been in court before, look to see if prior competence** proceedings were conducted.
- **Look at information about your client collected by the pretrial release program.** These programs may have collected some information on your client's mental health status in the course of determining his or her eligibility for pretrial bond.

WHAT RECORDS WOULD BE HELPFUL?

If it appears that your client has or has had significant mental disorders or received treatment and that his or her mental health history will likely play a role at some point in the proceedings, you may want to obtain the following records:

- **Medical records from doctors or clinics.** Texas law now allows mental health professionals affiliated with public programs to share information with defense counsel and others involved in assisting "special needs offenders" without first obtaining a release.[1]

- **Prior hospitalization records.** Has your client been hospitalized multiple times? Does he or she have a history of involuntary civil commitments? How long were the hospital stays typically?

- **Family records.** Your client's family may have records of prior evaluations, prior treatment, prior applications for services, school records, or juvenile records.

- **School records.** Your client may have been enrolled in special education classes or may have been in special programs while in school. Look for the designation of an emotional disturbance on these special education records.

- **Employment records.** Mental illness may have interfered with your client's ability to hold down long-term, stable employment. Look at your client's employment history. Has he or she had trouble keeping jobs? Has your client ever been a client of the Texas Rehabilitation Commission or other job training programs?

- **SSI or Social Security Disability Insurance (SSDI) benefit checks from the Social Security office.** This may be your client's only source of income if he or she has a serious mental illness. You can ask to see applications and paperwork pertaining to these benefit programs.

- **VA records.**

- **Military records.**

- **Child Protective Services records.**

Because many local agencies and departments may still not be familiar with the Texas Health & Safety Code's Section 614.017, it is probably a good idea to have your client sign a record release form at the time of your first interview if your client is competent and able to do so. Even better, call the institution from which you are seeking records and request a copy of its record release form. If your client cannot sign a medical records release form because he or she is incompetent or his or her competency is in question, you may be able to obtain the needed records by sending to the institution a certified copy of the order appointing you to the case. If none of these methods work, you may be able to obtain the records by getting a subpoena or a court order. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 595.001 *et seq.*, 611.001 *et seq.*

Finally, you may want to consider hiring a mitigation specialist who can gather the information discussed in this section for you. A mitigation specialist can also develop a bio-psycho-social history of your client. Once you have this information, see where it takes you.

SECTION 5
PRETRIAL OPTIONS

TRY TO GET THE CASE DISMISSED

You should be seeking ways to get your client's case dismissed. What may seem like a minor misdemeanor conviction could come back to haunt your client down the road. For example, a family violence assault conviction can enhance a second family violence assault charge to a third degree felony and two convictions for prostitution or shoplifting can enhance the third charge of either of these two offenses to a state jail felony. Also, a criminal conviction may make your client ineligible for public housing. You can attempt to get a dismissal in various ways, but if you have never represented a person with mental illness before, get help from someone who has before embarking on any of the courses of action set out below.

TALK WITH THE PROSECUTOR

If you have an indication that your client's mental illness may have played a role in the charged offense, you may want to talk to the prosecutor about dismissing your client's case. The prosecutor may be more inclined to share your conviction that your client suffers from a mental illness and that the mental illness affected your client's judgment at the time of the alleged offense if you clearly document your client's mental illness and then provide that documentation to the prosecutor. However, if you are new to practice or otherwise unfamiliar with the prosecutor in your court, you should talk to other attorneys in the community about the prosecutor's sensitivity or lack of it regarding mental health issues. If the prosecutor has a reputation for being less than sensitive about mental health issues, you may want to seek out another prosecutor or speak to the prosecutor's supervisor.

TALK WITH THE COMPLAINING WITNESS

The option of an outright dismissal may be more appealing to the prosecutor in a case where there is no alleged victim. If there is an alleged victim and the prosecutor does not seem inclined to dismiss your client's case, you may want to directly contact the alleged victim and, with your client's permission, present evidence of your client's mental illness to the alleged victim. The alleged victim might then go to the prosecutor and ask the prosecutor to drop the charges against your client. This approach, however, can backfire. You may end up only aggravating the alleged victim; so, be sure to discuss the pros and cons of this option carefully with your client before you proceed.

TALK WITH THE ARRESTING OFFICER

Finally, you may want to approach the arresting officer to see if he or she would be willing to ask the prosecutor to dismiss the charges, especially if your client is charged with a nonviolent offense or if there is no complaining witness. You may be able to get the officer to work with you if you bring him or her evidence of your client's mental illness.

RELEASE ON A PERSONAL BOND

If a quick dismissal is not an option and your client is competent to stand trial, you should speak to your client about whether to seek his or her release on bond. The Texas Code of Criminal Procedure provides for release of your client on a personal bond if your client has been charged with a non-violent offense, and agrees to submit to treatment. TEX. CODE CRIM. PROC. ANN. arts. 16.22 and 17.032. However, these sections require a mental health examination and treatment, and do not protect the statements made during the examination from being admitted into evidence against your client at trial.

Remember that the written report from the mental health examination will be submitted to you **and the prosecutor** and could be used against your client down the road. You and your client may decide to forego release on bond to avoid this mental health examination or to avoid having to submit to treatment or other conditions of bond. You and your client may also decide not to pursue a release on bond if your client is homeless or does not have a safe or stable place to live. If your client is in danger of picking up additional charges while on bond or failing to report to court in violation of his or her bond, it may significantly impair your chances of getting your client's case dismissed.

If you are further along in the pretrial process and your client has been determined to be incompetent, the Texas Code of Criminal Procedure provides that your client can be released on bail if the court determines that he or she can be adequately treated (in order to regain competence) on an outpatient basis. TEX. CODE CRIM. PROC. ANN. art. 46.02, § 5.

DIVERSION

If your client was arrested without a warrant, you may want to look at the Texas Health and Safety Code, section 573.001, which requires that apprehended persons with mental illness be taken to a mental health facility instead of a jail facility in certain situations. Also, there may be a memorandum of understanding between your local MHMR center and the jail in your community to divert mentally ill offenders from jail into a mental health facility. If section 573.001 applies in your client's case or there is a memorandum of understanding in your county, you should bring this to the attention of jail personnel who have the authority to divert your client to a mental health facility.

INVOLUNTARY COMMITMENT

There may be rare situations in which you want to explore this option with your client if your client meets the commitment criteria. *See* TEX. HEALTH & SAFETY CODE ANN. §574.034(h). For example, you may be able to broker a deal by which the prosecutor agrees to dismiss your client's case conditioned on your client's mental health commitment.

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SECTION 6

COMPETENCE EVALUATIONS AND HEARINGS

THE BASICS [2]

The question of competence to stand trial relates to a criminal defendant's mental state at the time of trial–not at the time of the alleged offense. In other words, determinations regarding your client's competence are not determinations on the merits of your client's case; and a determination of incompetence will not excuse the offense against your client.

Your client is "incompetent" to stand trial on criminal charges if he or she does not have (1) sufficient present ability to consult with his or her lawyer (you) with a reasonable degree of rational understanding; or (2) a rational, as well as a factual, understanding of the proceedings against him or her.

Your client's competence involves more than his or her ability to correctly identify the different actors in the court process (e.g., the prosecutor, judge, defense attorney, or bailiff). You may want to consider the following questions in determining whether it is appropriate to request a competence examination for your client:

- Does your client understand his or her legal situation?
- Does your client understand the charges against him or her?
- Does your client understand the legal issues/procedures in his or her case?
- Does your client understand the available legal defenses?
- Does your client understand the dispositions, pleas, and penalties possible?
- Can your client appraise the likely outcomes of his or her case?
- Can your client appraise his or her role and the roles of defense counsel, prosecutor, judge, jury, and witnesses in his or her case?
- Can your client identify and locate witnesses?
- Does your client trust you and communicate relevant information to you?
- Does your client comprehend instructions and advice?
- Can your client make decisions after receiving advice?
- Is your client able to collaborate with you on developing legal strategy?
- Can your client follow his or her own testimony and the testimony of others for contradictions or errors?
- Can your client testify about relevant information and be cross-examined if necessary?
- Can your client help you challenge prosecution witnesses?
- Can your client tolerate the stress of the trial process?
- Can your client refrain from irrational and unmanageable behavior in court?
- Can your client disclose pertinent facts about the alleged offense?

Your client has the burden of proving that he or she lacks competence to stand trial by a preponderance of the evidence. If there has been a prior finding of incompetence, the burden shifts to the prosecution to prove competence beyond a reasonable doubt.

COMPETENCE EXAMINTATIONS

WHEN IS IT APPROPRIATE TO REQUEST A COMPETENCE EXAMINATION?

Generally, issues relating to your client's competence to stand trial should be resolved before the trial on the merits. However, you can request a competence examination at any point during the proceedings at which you believe your client is not competent to stand trial – even if you are in the middle of trying your client's case on the merits. You should note that the American Bar Association (ABA) has resolved that it is improper to use competence procedures for purposes unrelated to the determination of competence, such as obtaining mitigation information, obtaining favorable plea negotiations, or delaying proceedings. STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2.(e) (1989).

Many attorneys find themselves in an ethical bind when their client objects to having the competence issue raised. Some clients facing misdemeanor charges just want to plea to the charges, spend a short time in jail, and then get out. Often, getting a psychiatric examination means that the client will spend more time in jail pending the examination, plus a lengthy time at the state hospital if he or she is found incompetent. The ABA stresses a lawyer's professional responsibility toward the court and the fair administration of justice as the paramount obligations in such an instance, and expects an attorney to advance the issue even over a client's objection whenever a good faith doubt arises about a defendant's competence to stand trial. STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(c) (1989). [3] Of course, if your client is competent to stand trial, he or she makes the final decision about how to dispose of his or her case regardless of whether you agree with this decision or not.

If you believe your client is incompetent to stand trial, you should request a competence evaluation, but also pursue any appropriate pretrial options discussed in Section V to get your client's case dismissed or, if appropriate, to get your client released on bond. If the case is not dismissed, you should know that competence examinations and hearings can be conducted even if your client is on bond or otherwise out of jail.

REQUESTING THE COMPETENCE EXAMINATION

File a motion requesting psychiatric evaluation if you believe your client is not competent to stand trial, whether your client is in jail or out on bond. Even though defense counsel usually files such a motion, the court itself or the prosecutor may move for a psychiatric evaluation if either has a good faith reason to believe your client may not be competent. If you are in a jurisdiction that commonly allows oral requests and the judge verbally denies your request for an evaluation, you should file a written motion reflecting your request and make sure that the judge rules on the motion on the record. This will protect you from grievances and set up proper grounds for appeal if necessary.

Considerations regarding the mental health expert: If the judge allows a competence examination, he or she must provide a disinterested expert experienced and qualified in mental health to examine your client. TEX CODE CRIM. PROC. ANN. art. 46.02, § 3. It is best to have a psychiatrist or doctoral-level psychologist with specialized forensic training, experience in the courtroom, and knowledge of the appropriate evaluation procedures to perform the evaluation and testify at the competence hearing. It is also best to have the competence exam provided by a different doctor from the one who is treating your client in the jail setting. STANDARDS RELATING TO GENERAL PROFESSIONAL OBLIGATIONS TO DEFENDANTS WITH MENTAL ILLNESS § 7-1.1.(d) (1989). The law allows an independent psychiatric examination. *See* TEX CODE CRIM. PROC. ANN. art. 46.02, § 3. In fact, judicial decisions in Texas have required the state to provide (or reimburse the expenses for) an independent medical expert for indigent defendants. BRIAN D. SHANNON & DANIEL H. BENSON, TEXAS CRIMINAL PROCEDURE AND THE OFFENDER WITH MENTAL ILLNESS: AN ANALYSIS AND GUIDE, at 44 (2nd ed. 1999), citing *DeFreece v. State*, 848 S.W.2d 150, 159 (Tex. Crim. App. 1993).

YOUR RESPONSIBILITIES REGARDING THE EXAMINATION:

- If you requested the competence examination, it is your responsibility to inform the mental health professional in writing of each specific matter to be addressed in the examination. You may want to tell the evaluator why you think your client is unable to assist you or participate in his or her defense.

- A judge might want the examination to cover not only competence issues, but also issues surrounding culpability at the time of the offense, as well as penalty phase issues such as future dangerousness in a capital case. Do not consent to an examination that might provide the prosecution with evidence that will damage your theory of the case.

- You should also obtain and submit to the examiner any record or information that the examiner regards as necessary for conducting a thorough evaluation on the matters referred.

- Make sure that the examination is conducted promptly after you request it, so that your client does not languish in jail.

The law protects statements made during the competence evaluation from being admitted in the trial on the merits.

PREPARING THE CLIENT FOR THE EXAMINATION

You need to prepare your client for the competence examination. Encourage cooperation. Explain the following to your client:

- the purpose and nature of the examination;
- the potential uses of any disclosures made during the examination;
- the conditions under which the prosecutor will have access to reports and other information obtained for the examination and the reports prepared by the evaluator;
- the conditions under which the examiner may be called to testify during sentencing; and
- that your client will be sent to a state hospital for the examination if he or she refuses to cooperate with the court-appointed expert during the examination.

CAN YOU BE PRESENT DURING THE COMPETENCE EXAMINATION?

Some courts allow counsel to be present during an examination, while others do not. Some allow an attorney to watch but not to speak. Your presence at the examination enables the evaluating professional to observe the attorney-client relationship and get a better idea about what your client may be asked to do to assist with his or her defense. If the prosecutor initiated the examination, and it is likely that the examiner will be a State's witness at trial, you may be better able to cross-examine the mental health examiner at trial if you are present during, or have viewed or listened to, the examination. However, your presence at the examination may inhibit your client from speaking candidly with the evaluator and may also make the examination vulnerable to a prosecutor's challenge on cross-examination. If you are not allowed to be present during the examination, or decide not to attend, you should inquire about videotaping or audiotaping the interview as an alternative.

WHAT TO EXPECT IN COMPETENCE REPORTS

You owe it to your client to make sure the doctor's report or evaluation is complete. If it is not, you should call the examining doctor, cite the law, and ask for a more complete report. *See* TEX. CODE CRIM. PROC. ANN. art. 46.02, § 3(d). Competence evaluations in Texas must address not only competence issues, but also whether a person is mentally ill or has mental retardation. *Id.* In fact, there should be a separate report from the evaluator that addresses mental illness. *Id.* You can use this information for mitigation or other purposes. If you believe the report is still inadequate or inaccurate, you can ask for a second opinion. You should inquire within the legal and mental health communities about other doctors who may be able to testify at the competence hearing on behalf of your client.

The competence report should **not** contain information or opinions concerning either your client's mental condition at the time of the alleged crime or any statements made by your client regarding the alleged crime or any other crime. It should not include any offense-related information. Nor should it express the opinion of the examiner on any questions requiring a conclusion of law or a moral or social value judgment properly reserved to the trier of fact.

CAN YOUR CLIENT "REGAIN" COMPETENCE?

Whatever the particular diagnosis or disorder, your client can most probably be restored, though not cured, through hospitalization, other treatment, and/or psychotropic medication. The best indicator of whether your client is restorable, and in what time frame you can expect this restoration, is your client's history of response to treatment.

THE COMPETENCE HEARING

HOW THE RESULTS COULD AFFECT YOUR CLIENT'S CASE

The jury's determination at the competence hearing may affect how you proceed on the merits of your client's case:

- **If your client is determined by the jury to be competent:** Again, if you have documented evidence that your client suffers from a mental illness that may have impaired his or her judgment at the time of the alleged offense, you should explore the dismissal options set out in section V.

- **If your client is determined by the jury to be incompetent to stand trial but it is anticipated that he or she will regain competence in the foreseeable future,** the criminal court will order a "criminal commitment" to the appropriate mental health facility for a period not to exceed 18 months. TEX. CODE CRIM. PROC. ANN. art. 46.02, § 5. If your client has regained his or her competence after returning from the mental health facility, you should explore appropriate dismissal and release options (such as having the court set bail). You should also know that if your client decides to enter a plea agreement after returning from the mental health facility, the Texas Code of Criminal Procedure provides that the time your client spent confined in the mental health facility pending trial shall be credited to the term of his or her sentence. TEX. CODE CRIM. PROC. ANN. art. 42.06, § 9. You should try to secure a trial setting well in advance of your client returning from the mental health facility. If, after regaining competence, your client decides to go to trial, you should be ready to try the case quickly so that your client does not deteriorate and become incompetent again before you get to trial.

- **If your client is determined by the jury to be incompetent to stand trial and there is a finding that he or she will likely not regain competence in the foreseeable future,** civil commitment proceedings will be undertaken. The procedures differ depending on whether the criminal charges have been dismissed. If the charges have not been dismissed, the criminal court retains jurisdiction and must conduct the civil commitment proceedings (whether or not the criminal court is also the county court). TEX. CODE CRIM. PROC. ANN. art. 46.02, § 6. If the criminal charges

have been dismissed, the criminal court must determine whether there is evidence indicating that the defendant is mentally ill. If so, the criminal court must transfer your client to the appropriate civil court for civil commitment proceedings. TEX. CODE CRIM. PROC. ANN. art. 46.02, § 7. You should know, however, that just because your client is mentally ill does not mean he or she will necessarily meet the requirements for civil commitment. Many criminal court judges may be unaware that dismissed cases are handled differently from cases that have not been dismissed. You may be able to use this distinction to your client's advantage, depending on the court you are in and the seriousness of the alleged offense. For example, a judge who handles misdemeanors may have never conducted a civil commitment proceeding – and may not want to start now. If you can impress upon the judge that a dismissal of your client's case will transfer the responsibility of the civil commitment proceeding to another court, the judge might urge the prosecutor to dismiss the case.

If your client is going to attend the competence hearing, you should encourage him or her to behave appropriately in court.

Texas
APPLESEED

Notes

SECTION 7
THE INSANITY DEFENSE

THE BASICS

A plea of not guilty by reason of insanity (NGRI) is an affirmative defense to prosecution in Texas. Insanity under Texas law means that at the time of the conduct charged, and as a result of severe mental disease or defect, the defendant did not know that his or her conduct was wrong. For a verdict of not guilty by reason of insanity to be returned, the prosecution must have established beyond a reasonable doubt that your client committed the alleged act, and your client must establish, by a preponderance of the evidence, that he or she was insane at the time of the alleged conduct. Neither you, the court, nor the prosecutor can inform any juror or prospective juror of the consequences to your client, described below, if a verdict of not guilty by reason of insanity is returned.[4]

You should be very cautious in selecting the insanity defense. Many potential jurors believe that the defense of insanity is simply an excuse or trick used by defense attorneys to get their clients "off the hook." You should also know that Texas' test for insanity is narrow compared with that of many jurisdictions; it does not include your client's ability to conform his or her conduct to the requirements of the law. If you decide to proceed with an insanity defense, you should make sure that your mental health expert understands this.

GET GOING EARLY

If you are contemplating an insanity defense, find a reputable doctor (psychologist or psychiatrist) as quickly as you can and have that individual immediately interview your client. Have the interview videotaped if you can, especially if your client is exhibiting signs of psychosis. Your client may be promptly given medication that will alleviate the symptoms of his or her mental illness. The symptoms of your client's mental illness need to be preserved as evidence for the jury before this medication takes effect.

If you can show that insanity will be a significant factor in the case, your client is entitled to obtain expert assistance in preparation of the defense. *De Freece v. State*, 848 S.W.2d 150, 159 (Tex. Crim. App.), *cert. denied*, 510 U.S. 905 (1993). You should file an ***ex parte*** application to the trial court for this expert assistance. *Williams v. State*, 958 S.W.2d 186, 192 (Tex. Crim. App. 1997). You can consult with this expert after he or she has evaluated your client and then make a decision about whether to go forward with the insanity defense. If you and your client decide not to do so, the prosecutor will not know about the evaluation or the expert's findings. If you decide to go forward with an insanity defense, you should know that the court can order you to disclose the names of all of your witnesses, including your mental health expert, before trial. TEX. CODE CRIM. PROC. ANN. § 39.14(b). If you are pursuing the insanity defense, you should also know that your client may be required to submit to a mental health evaluation, the results of which will be filed with the court and made available to both you and the prosecutor. TEX. CODE CRIM. PROC. ANN. art. 46.03, § 3(a).

DISPELLING THE MYTH

There is a popular myth that a person who is found not guilty by reason of insanity just walks away. It is true that, like a simple not guilty verdict, an NGRI verdict is considered a full acquittal of all charges. However, unlike a simple not guilty verdict, the court conducts a hearing after an NGRI verdict to determine, first, whether there was an act, attempt, or threat of serious bodily injury to anyone and, if not, whether there is evidence that the accused is mentally ill.

- **If there is no act, attempt, or threat of serious bodily injury to anyone**, but there is evidence of present mental illness, then the criminal court must transfer the case to the appropriate civil court for civil commitment proceedings.

- **If there is no act, attempt, or threat of serious bodily injury** to anyone and there is no evidence of present mental illness, then your client is free to go.

- **If there is an act, attempt, or threat of serious bodily injury,** then the criminal court retains jurisdiction and must order that your client be committed to the maximum security unit within the Texas Department of MHMR. Then, the criminal court must conduct a commitment hearing pursuant to the Mental Health Code within 30 days of the acquittal. The criminal court retains jurisdiction for further inpatient or outpatient requirements if the commitment hearing reveals the need for further treatment. TEX. CODE CRIM. PROC. ANN. art. 46.03, § 4. You should know, however, that the criminal court cannot commit your client to a mental hospital or other in-patient or residential facility for "a cumulative period of time which exceeds the maximum term provided by law for the crime for which [your client] was tried [and acquitted]. Upon expiration of that maximum term, [your client] may be further confined in such a facility only pursuant to civil commitment proceedings." TEX. CODE CRIM. PROC. ANN. art. 46.03, § 4(d)(7).

KNOWING THE LAW WILL GIVE YOU A BIG ADVANTAGE

Unfortunately, the myth addressed above is not just shared by the public at large, but by many judges, defense lawyers, and prosecutors. You will have a large advantage if you know the law. For example, if you try your client's case to the judge, the judge might be reluctant to find your client not guilty by reason of insanity if he or she is operating under the myth that your client will automatically go free upon such a verdict—especially if your client is charged with a violent crime. The judge may feel that a guilty verdict, coupled with probation, will allow your client to get treatment, but will also allow the court to retain some degree of control over your client. By advising the judge that the court can likely both reach a verdict of not guilty by reason of insanity and maintain jurisdiction over your client, you can go a long way toward giving your client a zealous representation.

Knowing the law will also help you and your client decide whether the case should be tried before a judge or a jury. You may want to consider trying your case to the judge instead of a jury because you cannot advise the jury, or jury panel, of the consequences to your client if a verdict of not guilty by reason of insanity is returned—so chances are that the jury will be operating under the myth that your client will simply go free if such a verdict is returned.

SECTION 8

USE OF EXPERT MENTAL HEALTH WITNESSES, MITIGATION, AND SENTENCING STRATEGIES

EXPERT MENTAL HEALTH WITNESSES

HOW THEY CAN HELP YOU

Information obtained from mental health experts can help you make informed decisions about:

- the manner in which you relate to your client;
- your client's competence to proceed;
- your client's mental state at the time of the offense;
- plea negotiations;
- jury selection;
- whether or not your client should testify;
- medical treatment or other services for your client while the case is pending;
- what types of assessments or evaluations are needed; and
- the selection of witnesses for the trial, including the penalty phase.

HOW CAN YOU GET THEM?

The incremental approach set out below may not always be practical. Some judges may determine that a misdemeanor case does not warrant the use of an expert witness or that one expert is all you get—even in a felony case. Consult with attorneys in your community about how to get experts appointed in your case. There may be some standard form motions that you can use. Also, remember that the Fair Defense Act provides for the reimbursement of reasonable and necessary expenses, including mental health experts. Be sure to make a record if you cannot get the experts or resources you need.

THE INCREMENTAL APPROACH–START WITH A MITIGATION SPECIALIST

When deciding whom to obtain as your mental health expert(s), you may want to consider first consulting a mitigation specialist, who will often be a licensed social worker. The mitigation specialist will:

- conduct a thorough bio-psycho-social history investigation;
- interview your client;
- conduct collateral interviews;
- gather your client's medical records; and
- determine what cultural, environmental, and genetic circumstances might have factored into your client's case.

Mitigation specialists are superior in many cases to using traditional law-enforcement type investigators in developing mitigating evidence because they have training in the human sciences and an appreciation for the variety of influences that may have affected your client's development and behavior. At any rate, the person conducting the investigation should have training, knowledge, and skill to detect the presence of factors such as:

- mental disorders;
- neurological impairments;
- cognitive disabilities;
- physical, sexual, or psychological abuse;
- substance abuse; and
- other influences on the development of your client's personality and behavior.

Mitigation investigations should be thorough and extensive, especially in capital cases where the whole of the defendant's life needs to be judged in order to determine whether to spare her or him from execution. On the other hand, if your client is charged with a misdemeanor, it may be enough simply to use the social worker mitigation expert, or another qualified investigator, as your only expert in the case.

THEN, YOU MAY WANT TO MOVE ON TO A CONSULTING PSYCHOLOGIST

The mitigation expert may then confer with a consulting psychologist, who will review the records and be able to determine what kinds of expert witnesses you may need and what role you want them to play. In some cases, you need a professional with specialized expertise in testing intellectual functioning. Other times you want a person with specialization in personality testing. Or you may want someone trained in the area of sexual trauma to interview your client. The consulting psychologist will only refer specific aspects of your client's case to the testifying experts, who will interview your client in preparation for courtroom testimony.

NEXT, FOCUS ON YOUR TESTIFYING EXPERTS

You need to pay attention to the testifying expert's qualifications and select someone who will be the most credible and persuasive to the court and jury. It is important for testifying experts to be forensically trained since they will have a better understanding of the legal questions that need to be answered. You should thoroughly investigate the expert's background and prior testimony. It is good to have someone who has testified before and knows how to handle cross-examination. If your client's primary language is not English, you may want to consider hiring an expert who is fluent in your client's primary language. Testifying expert witnesses fall into several categories, and you should pick one who can best meet your needs:

- For testimony related to diagnosis, treatment, and medication for mental disorders and medical issues, you should obtain a psychiatrist as your testifying expert witness, preferably one with a forensic specialization.
- For testimony related to personality or behavioral disorders, intellectual or cognitive functioning, or administering and interpreting tests, you should obtain a psychologist as your testifying expert witness.
- If your client has a brain injury or has problems with memory, language, or orientation functions, you may want to obtain a neuropsychiatrist or a neuropsychologist.

You may also want to use a pharmacologist, or a specialist in addiction medicine or in sexual trauma if appropriate.

Local mental health professionals may not have the expertise you need. Also, some experts may feel beholden to local authorities for future income. If any circumstances arise that cause you to question the objectivity of the local health professional in question, you should seek expert assistance elsewhere.

This incremental approach to developing mental health evidence is considered by some to be superior to the "complete psychological evaluation" that attorneys often request, particularly in capital cases. This suggested approach may be more cost efficient, more likely to produce information that will advance your theory of the case, and less likely to generate information that will be of no use or, worse, will harm your theory and your client. Ideally, the same professional should not fill more than one role (evaluator, consultant, or treatment provider). STANDARDS RELATING TO GENERAL OBLIGATIONS TO DEFENDANTS WITH MENTAL ILLNESS § 7-1.1. (1989).

MITIGATION

WHY IS MITIGATION IMPORTANT?

Mitigation is not a defense to prosecution. It is not an excuse for committing the crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or condition that invites compassion. Mitigation is the explanation of what influences converged in the years, days, hours, minutes, and seconds leading up to the crime, how information was processed in a damaged brain, and the behavior that resulted.

Human beings can react punitively toward a person whom they regard as defective, foreign, deviant, or fundamentally different from themselves. A client's bizarre behavior or symptoms may be misunderstood by jurors or engender such fear that this behavior becomes an excuse to punish the defendant rather than a basis for mercy. Good mental health experts can provide testimony at the punishment phase to help the jury understand who your client is, how he or she experiences the world, and why your client behaves as he or she does. They help you humanize your client so that the judge and jury see him or her as a person who deserves empathy and compassion. Many lives are spared in capital sentencing proceedings when jurors come to understand empathetically the disabilities, brain damage, and tormented psyche that may have led to a client's behavior. When presenting mitigation evidence, you must show the relationship between the disability and the conduct. It is not the "What?" It is the "So what?" If you cannot answer the "So what" question that each juror will be asking, the evidence of disability will look like an excuse, not an explanation.

SENTENCING STRATEGIES

When thinking about sentencing with your mentally ill client, there are a number of things you should consider and weigh.

MENTAL HEALTH INFORMATION AS MITIGATION CAN SOMETIMES HURT YOU.

You need to consider carefully the decision to raise your client's mental illness to the jury. Some jurors do not believe in mental illness. Some jurors will not want your client to be out in the community on probation. Your client's mental illness may become fair game for argument; the state may try to use it against you. The prosecutor might say, "What's to keep this person from going off his medications again?" Or the prosecutor might suggest that "We have to keep mentally ill people locked up for our own safety." On the other hand, you must remember that failing to raise the issue of your client's mental illness may result in a probated sentence that your client cannot comply with or in a period of incarceration that will further damage your client's mental health.

IF YOU DECIDE TO RAISE YOUR CLIENT'S MENTAL ILLNESS AT THE PUNISHMENT PHASE, BE SURE YOU HAVE SUFFICIENT EVIDENCE AND EXPERT HELP.

You need to be able to say more than that your client is depressed. You need to talk about the extent of the depression. Was your client depressed for a short period or was it more serious? Unless it is a very serious case that can be substan-

tiated, jurors may think, "We've all been depressed" or "Everyone's depressed while they're in jail." Remember, the scope of the jury's inquiry at the punishment phase is much broader than at the guilt/innocence phase. There are different types of mental health experts, diagnoses, and resources that may be helpful. Simply interviewing your client or submitting him or her for a single mental health exam will almost always result in an incomplete picture.

YOU MAY BE BETTER OFF ADVISING YOUR CLIENT TO WAIVE A JURY AND TAKING THE MENTAL HEALTH EVIDENCE DIRECTLY BEFORE THE JUDGE.

The decision to go to the jury or the judge for sentencing depends on several things, including the charges involved, the judge, and how much the prosecutor is willing to work with you. If your client decides to go to the judge for sentencing and you are seeking probation, you should have a plan for the judge to consider – a stable place for your client to live, a doctor to go to, and some program to provide supervision to help your client stay out of trouble. Be an advocate for your client. Bring in witnesses who know your client, such as his or her psychiatrist, his or her MHMR caseworker, and family members. If your client is on probation and the state has filed a motion to revoke or a motion to adjudicate guilt, you should seek the above-mentioned sources to keep the judge from revoking your client's probation or entering a conviction on the record against your client and sending him or her to jail. You can also have the probation officer handling your client's case testify about whether your client is on a specialized caseload.

MAKE SURE YOUR CLIENT RECEIVES AN ACCURATE AND COMPLETE MENTAL HEALTH EVALUATION.

If you are going to bring your client's mental illness before the judge or jury for sentencing purposes, make sure that the experts you use do more than conduct a mental status examination and offer a diagnosis. You should work with the expert to ensure that he or she conducts a wider-ranging inquiry into your client's mental health history and its implications. For example, your client may have incurred a head injury at an early age, causing brain damage. Or there may be a familial history of mental illness or a generational pattern of violence and abuse in the home. It is important to interview outside sources such as family members, former teachers, physicians, etc., as well as to request all available records. A comprehensive mental health examination should include:

- a thorough physical and neurological examination;
- a complete psychiatric and mental status examination;
- diagnostic studies, including personality assessment;
- neuropsychological testing;
- appropriate brain scans; and
- a blood test or other genetic studies.

In capital defense litigation, it is especially important to make sure your client has thorough and comprehensive mental examinations that evaluate each area of concern as indicated by the client's bio-psycho-social history.

MANY MENTALLY ILL OFFENDERS HAVE CO-OCCURRING SUBSTANCE ABUSE PROBLEMS.

Many persons with mental illness have addictions to drugs and/or alcohol; others "self-medicate" the symptoms of their mental illness with drugs or alcohol. Under either scenario, it is likely that this type of client will have problems staying clean and/or being successful on probation. Both substance abuse and mental illness are chronic, relapsing illnesses that need treatment. If your client has a substance abuse problem and also a serious mental illness, you should look into the availability of dual diagnosis treatment programs in your community. The Substance Abuse Felony Punishment (SAFP) facilities in Texas treat persons with drug and/or alcohol addictions, but generally have long waits to get in. Some clients would rather accept a plea bargain agreement for jail time than wait to get into substance abuse or dual diagnosis treatment. Your client makes the ultimate decision about whether to get treatment, but you should talk candidly with your client about it. Try say-

ing something like, "Look, you have this problem and you're probably not going to make it on probation. You're going to end up in the penitentiary–but we can get you some treatment to help you avoid that." Talk to your client about doing what is best for him or her over the long term rather than the short term.

YOUR CLIENT'S MENTAL ILLNESS SHOULD BE FACTORED INTO DECISIONS ABOUT PROBATION.

Your client may need special attention if he or she is seeking probation: Remember that your client may not be able to hold down full time employment, pay probation fees, keep track of appointments, navigate public transportation, perform community service, or complete schooling the way that other clients can. Special arrangements may need to be made and extra help may need to be provided if these tasks are part of the successful completion of your client's sentence. If your client is taking probation, you should work to assure that your client gets probation with treatment or gets conditions placed on his or her probation that will help him or her successfully complete the probation. If your client is facing revocation of his or her probation, you should educate the court about your client's mental illness and the treatment options that could be made part of the conditions of his or her probation.

The judge's ability to condition probation on treatment: The Texas Code of Criminal Procedure now specifically authorizes judges to require certain offenders suffering from mental illness to submit to outpatient or inpatient mental health treatment as a condition of community supervision stemming from probated or suspended sentences.[5] TEX. CODE CRIM. PROC. ANN. art. 42.12, § 11(d). In general, before a court may impose a mental health treatment condition on your client's community supervision, a mental health expert must have examined your client and the court must find that either a) your client's mental illness is chronic, or b) his or her ability to function independently will continue to deteriorate without proper treatment. *Id.* The statute also requires the court to take steps to assure that appropriate outpatient or inpatient mental health services are available either through MHMR or another provider.

The judge can amend the conditions of probation: For example, if the judge mandates that a person be treated in an inpatient setting, but his or her condition improves greatly, the court can then modify the order to authorize outpatient treatment.[6] These statutes provide a great deal of flexibility to tailor appropriate conditions of treatment for offenders suffering from mental illness. Although mental health treatment may include medication, attorneys and judges are generally not in the best position to make judgments about specific medication options. However, you should advocate for the best available treatment for your client.

Specialized probation caseloads: You may want to ask for your client to be placed on a specialized probation caseload. These are special units set up for adults with serious mental illnesses. The officers who work in these special units have usually received extra training about mental illness and monitor a smaller number of clients. Bring your client's problems to the attention of both the judge and probation department. Tell the probation department that your client has special needs and seek accommodations for your client through the probation department. If you think that your client may deteriorate soon after being placed on probation, ask the probation department if it will authorize a psychological examination; sometimes this can be done before the plea and you can use the results of this examination to further negotiate probation terms for your client.

Be especially careful if your client is considering deferred adjudication probation: The Texas Code of Criminal Procedure permits a court to condition deferred adjudication probation on whether your client obtains mental health treatment. TEX. CODE CRIM. PROC. ANN. art. 42.12. However, if your client cannot successfully complete the conditions of his or her deferred adjudication probation, the judge can convict him or her and the judge will have the **full range** of punishment under which to impose a sentence. On the other hand, if your client successfully completes his or her deferred adjudication probation, he or she will avoid a criminal conviction and will still be eligible for certain housing and job opportunities that are closed to people with felony convictions.

YOUR CLIENT MAY NOT WANT TREATMENT.

You cannot force your client to get treatment if he or she does not want it, even though you know it may be in his or her long-term interest. You may be limited in what you can do for your client. If your client's charges are minor and he or she has a supportive family, has a safe place to live, is usually relatively stable, and is competent, it may be better for your client to plead to jail time if you can negotiate a good deal rather than pursuing the insanity defense, even if applicable, or accepting a probated sentence. However, you have an obligation to set out all the pros and cons of any plea bargain agreement for your client. If your client is considering straight jail time, you should tell him or her the possible benefits of taking probation with conditions that require treatment. Tell your client what you believe the chances are of him or her staying out of trouble if he or she does not get treatment, and what penalties might await your client if he or she re-offends.

GO THE EXTRA MILE FOR YOUR CLIENT.

Persons with mental illness who are not linked with appropriate services at sentencing are likely to re-offend, perhaps with more serious consequences and penalties attached to the second or third arrest. Try to set up your client with ongoing treatment and services so that he or she will stay out of trouble. If your client is going to the penitentiary, you should recommend that he or she be sent to a specialized mental health unit. If your client is being released on probation, stable housing is especially important. Talk with the probation department about the resources it uses. Call the local Mental Health Association, the local chapter of the National Alliance for the Mentally Ill (NAMI), or the local MHMR center for recommendations about services. Every MHMR center in Texas is supposed to have an individual designated to respond to requests for information from courts, judges, and attorneys.

ENDNOTES

[1]The Texas Health and Safety Code allows the exchange of information, notwithstanding other confidentiality requirements, between defense attorneys, law enforcement agencies, MHMR facilities, a number of state health and human service agencies, community supervision and corrections departments, pretrial release offices, local jails, municipal or county health departments, hospital districts, and criminal court judges. TEX. HEALTH & SAFETY CODE ANN. § 614.017. The information exchange is for the purpose of assuring continuity of care and treatment for the mentally ill offender. The statute does not cover private health or mental health facilities or include substance abuse treatment records, which are protected under federal law.

[2]You should note that the 77th session of the Texas Legislature appointed a task force to study competency and insanity procedures in Texas and recommend changes.

[3]Compare, however, the Texas Health and Safety Code requirement with respect to civil commitment that an attorney must follow the instructions of his or her client on the issue of court-ordered treatment, regardless of the attorney's own position on the matter. TEX. HEALTH & SAFETY CODE ANN. § 574.004 (c). No similar language appears in the Texas Code of Criminal Procedure with regard to whether to pursue an initial competence evaluation, although the Texas Code of Criminal Procedure references the Texas Health and Safety Code regarding the civil commitment of persons already determined to be incompetent.

[4]Nevertheless, you may want to consider tendering an instruction that would accurately inform the jury about what would happen to your client if the jury returned an NGRI verdict.

[5]The court may also condition a state jail felony offender's community supervision on his or her obtaining inpatient or outpatient mental health treatment. TEX. CODE CRIM. PROC. ANN. art. 42.12, § 15. A parole panel may also place similar conditions on a defendant's parole. TEX. GOV'T CODE § 508.221.

[6]Texas law also provides "Special Needs Parole" for certain identified populations, including persons with mental illness. TEX. GOV'T CODE § 508.146.

Notes

GLOSSARY
OF COMMON MENTAL HEALTH TERMS

ADD – see attention deficit/hyperactivity disorder.

ADHD – see attention deficit/hyperactivity disorder.

Affect – a person's immediate emotional state or mood that can be recognized by others.

Affective disorder – a mental disorder characterized by disturbances of mood. Depression, mania, "manic-depression," and bipolar disorders in which the individual experiences both extremes of mood are examples. Also called mood disorder.

Antisocial personality – a type of personality disorder marked by impulsivity, inability to abide by the customs and laws of society, and lack of anxiety, remorse, or guilt regarding behavior

Anxiety – a state of apprehension, tension, and worry about future danger or misfortune. A feeling of fear and foreboding. It can result from a tension caused by conflicting ideas or motivations. Anxiety manifests through symptoms such as palpitations, dizziness, hyperventilation, and faintness.

Anxiety disorders – a group of mental disorders characterized by intense anxiety or by maladaptive behavior designed to relieve anxiety. Includes generalized anxiety and panic disorders, phobic and obsessive-compulsive disorders, social anxiety, and post-traumatic stress disorder.

Antidepressants – medications used to elevate the mood of depressed individuals and also to relieve symptoms of anxiety conditions.

Antipsychotic medications – medications that reduce psychotic symptoms; used frequently in the treatment of schizophrenia.

Attention Deficit/Hyperactivity Disorder (ADHD) – a disorder, usually of children but also present in adults, characterized by a persistent pattern of inattention and/or hyperactivity and impulsivity that is more frequent and severe than is typically found in individuals of a comparable level of development. Symptoms might include impatience, fidgetiness, excessive talking, inability to focus or pay attention, and distractibility.

Atypical antipsychotics – a new group of medications used primarily to treat schizophrenia with broader effectiveness and few side effects. Also called new generation antipsychotics.

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Atypical antipsychotics – a new group of medications used primarily to treat schizophrenia with broader effectiveness and few side effects. Also called new generation antipsychotics.

Auditory hallucinations – voices or noises that are experienced by an individual that are not experienced by others.

Autism – a mental disorder, first evident during early childhood, in which the child shows significant deficits in communication, social interaction, and bonding and play activities, and engages in repetitive behaviors and self-damaging acts.

Behavior therapy – a method of therapy based on learning principles. It uses techniques such as reinforcement and shaping to modify behavior.

Behavioral health – a term used to refer to both mental illness and substance abuse.

Benzodiazepines – a class of anti-anxiety medications that have addiction potential in some people.

Bipolar disorder – a mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called manic-depression.

Borderline personality disorder – a mental disorder in which the individual has manifested unstable moods, relationships with others, and self-perceptions chronically since adolescence or childhood. Self-injury is frequent.

Clinical psychologist – a psychologist, usually with a Ph.D. or Psy.D. degree, trained in the diagnosis and treatment of emotional or behavioral problems and mental disorders.

Cognitive behavior therapy – a therapy approach that emphasizes the influence of a person's beliefs, thoughts, and self-statements on behavior. It combines behavior therapy methods with techniques designed to change the way the individual thinks about self and events.

Cognitive impairment – a diminution of a person's ability to reason, think, concentrate, remember, focus attention, and perform complex behaviors.

Compulsion – the behavioral component of an obsession. A repetitive action that a person feels driven to perform and is unable to resist; ritualistic behavior.

Conduct disorder – a childhood disorder characterized by a repetitive and persistent pattern of behavior that disregards the basic rights of others and major societal norms or rules.

DSM-IVR – the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, revised. This is a nationally accepted book that classifies mental disorders. It presents a psychiatric nomenclature designed for diagnosing different categories of and specific psychiatric disorders.

Decompensation – a gradual or sudden decline in a person's ability to function accompanied by the re-emergence of psychiatric symptoms.

Delusion – false beliefs characteristic of some forms of psychotic disorder. They often take the form of delusions of grandeur or delusions of persecution.

Dementia – a chronic organic mental illness which produces a global deterioration in cognitive abilities and which usually runs a deteriorating course.

Depression – an affective or mood disorder characterized by a profound and persistent sadness, dejection, decreased motivation and interest in life, negative thoughts (for example, feelings of helplessness, inadequacy, and low self-esteem) and such physical symptoms as sleep disturbances, loss of appetite, and fatigue and irritability.

Disruptive behavior disorder – a class of childhood disorders including conduct disorder, oppositional defiant behavior, and attention deficit/hyperactivity disorder

Dissociative identity disorder – see multiple personality disorder.

Electroconvulsive therapy – a treatment for severe depression in which a mild electric current is applied to the brain, producing a seizure similar to an epileptic convulsion. Also known as electroshock therapy. It is most often used to treat severe, persistent depression.

Electroshock therapy – electroconvulsive therapy.

Family therapy – psychotherapy with the family members as a group rather than treatment of the patient alone aimed at addressing family dysfunction and leading to improved family function.

Fetal alcohol syndrome – abnormal development of the fetus and infant caused by maternal alcohol consumption during pregnancy. Features of the syndrome include retarded growth, small head circumference, a flat nasal bridge, a small midface, shortened eyelids, and mental retardation.

Generalized anxiety disorder – an anxiety disorder characterized by persistent tension and apprehension. Maybe accompanied by such physical symptoms as rapid heart rate, fatigue, disturbed sleep, and dizziness.

Group therapy – a group discussion or other group activity with a therapeutic purpose participated in by more than one client or patient at a time.

Hallucination – a sensory experience in the absence of appropriate external stimuli that is not shared by others; a misinterpretation of imaginary experiences as actual perceptions.

Hypomania – an affective disorder characterized by elation, overactivity, and insomnia.

Illusion – a misperception or misinterpretation of a real external stimulus so that what is perceived does not correspond to physical reality.

Impulse control disorders – a category of disorders characterized by a failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. A number of specific disorders, including substance abuse disorders, schizophrenia, attention deficit/hyperactivity disorder, and conduct disorder have impulse control features.

Learning disorders – learning problems that significantly interfere with academic achievement or activities of daily living involving reading, math, or writing. They are typically diagnosed from achievement on standardized tests.

Lithium carbonate – a compound based on the element lithium that has been successful in treating bipolar disorders.

MRI (magnetic resonance imaging) – a computer-based scanning procedure that generates a picture of a cross-section of the brain or body.

Malingering – feigning or significantly exaggerating symptoms for a conscious gain or purpose such as to get a change in conditions of confinement.

Mania – an affective disorder characterized by intense euphoria or irritability, exaggerated excitement, overactivity, and loss of insight.

Manic-depressive disorder – A mood disorder in which people experience episodes of depression and mania (exaggerated excitement) or of mania alone. Typically the individual alternates between the two extremes, often with periods of normal mood in between. Also called bipolar disorder.

Mental illness – a generic term used to refer to a variety of mental disorders, including mood disorders, thought disorders, eating disorders, anxiety disorders, sleep disorders, psychotic disorders, substance abuse disorders, personality disorders, behavioral disorders, and others.

Mental retardation – a permanent condition usually developing before 18 years of age that is characterized by significantly subaverage intellectual function accompanied by significant limitations in adaptive functioning in other areas such as communication, self-care, home living, self-direction, social/interpersonal skills, work, leisure, and health.

Mood disorder – a mental disorder characterized by disturbances of mood. Depression, mania, and bipolar disorders, in which the individual experience both extremes of mood, are examples. Also called affective disorder.

Multiple personality disorder – the existence of two or more distinct identities or personalities within the same individual. Each identity has its own set of memories and characteristic behaviors. The identities are believed to develop as a way of protecting the individual from the effects of severe abuse or trauma. Also called dissociative identity disorder.

Neuroimaging – newly developed computerized techniques that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task. Two common neuroimaging techniques are positron emission tomography (PET) and magnetic resonance imaging (MRI).

Neurosis (pl. neuroses) – a mental disorder in which the individual is unable to cope with anxieties and conflicts and develops symptoms that he or she finds distressing, such as obsessions, compulsions, phobias, or anxiety attacks. This is no longer a diagnostic category of DSM-IVR.

Nervous breakdown – a non-technical term used by the lay public, usually referring to an episode of psychosis.

Neuroleptic drugs – a category of older medications used to treat psychoses. Many have been linked to neurological side effects.

New generation antipsychotics – *see atypical antipsychotics.*

Obsession – An unpleasant or nonsensical thought that intrudes into a person's mind, despite a degree of resistance by the person. Obsessions may be accompanied by compulsive behaviors. A persistent, unwelcome, intrusive thought.

Obsessive-compulsive disorder – an anxiety disorder involving recurrent unwelcome thoughts, irresistible urges to repeat stereotyped or ritualistic acts, or a combination of both of these.

Oppositional defiant disorder – a childhood disorder characterized by a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists over time.

Panic attack – a sudden onset of intense apprehension, fearfulness, or terror often associated with feelings of impending doom, imminent heart attack, or other fears which often drive someone to seek medical care.

Panic disorder – an anxiety disorder in which the individual has sudden and inexplicable episodes of terror and feelings of impending doom accompanied by physiological symptoms of fear (such as heart palpitations, shortness of breath, muscle tremors, faintness).

Paranoia – a pervasive distrust and suspiciousness of others; suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Paranoid schizophrenia – a schizophrenic reaction in which the patient has delusions of persecution.

Personality disorder – an enduring pattern of perceiving, relating to, and thinking about the environment and oneself that begins by early adulthood, is exhibited in a wide range of personal and social contexts, and leads to impairment or distress; it is a constellation of traits that tend to be socially maladaptive.

Phobia – excessive fear of a specific object, activity, or situation that results in a compelling desire to avoid it.

Phobic disorder – an anxiety disorder in which phobias are severe or pervasive enough to interfere seriously with the individual's daily life.

Positron emission tomography (PET scan) – a newly developed technique that can create visual images of a brain in action and indicate which regions of the brain show the most activity during a particular task.

Post-traumatic stress disorder – an anxiety disorder in which a stressful event that is outside the range of usual human experience, such as military combat or a natural disaster, induces symptoms such as a re-experiencing of the trauma and avoidance of stimuli associated with it, a feeling of estrangement, a tendency to be easily startled, nightmares, recurrent dreams, and disturbed sleep.

Psychiatrist – a medical doctor specializing in the treatment and prevention of mental disorders both mild and severe.

Psychoactive drugs – drugs that affect a person's behavior and thought processes, including non-prescription or "street" drugs.

Psychotropic drugs – prescribed medications that affect a person's behavior and thought processes.

Psychoanalysis – a method of intensive and in-depth treatment for mental disorders emphasizing the role of unconscious processes in personality development and unconscious beliefs, fears, and desires in motivation.

Psychologist – a person with a Masters degree, Ph.D., Ed.D., or Psy.D., and a license in psychology, the study of mental processes and behavior. Psychologists can specialize in counseling and clinical work with children and/or adults who have emotional and behavioral problems, testing, evaluation, and consultation to schools or industry, but cannot prescribe medications.

Psychopathic personality – a behavior pattern that is characterized by disregard for, and violation of , the rights of others and a failure to conform to social norms with respect to lawful behavior.

Psychosis (pi. psychoses) – a severe mental disorder in which thinking and emotion are so impaired that the person is seriously out of contact with reality.

Psychosomatic disorder – physical illness that has psychological causes.

Psychotherapy – treatment of personality maladjustment or mental disorders by interpersonal psychological means.

Psychotic behavior – behavior indicating gross impairment in reality contact as evidenced by delusions and/or hallucinations. It may result from damage to the brain or from a mental disorder such as schizophrenia or a bipolar disorder, or a metabolic disorder.

Repression – a defense mechanism in which an impulse or memory that is distressing or might provoke feelings of guilt is excluded from conscious awareness.

Schizoaffective Disorder – a mental disorder in which in which a mood disturbance and the active symptoms of schizophrenia occur together.

Schizophrenia – a group of mental disorders characterized by major disturbances in thought, perception, emotion, and behavior. Thinking is illogical and usually includes delusional beliefs; distorted perceptions may take the form of hallucinations; emotions are flat or inappropriate. The individual withdraws from other people and from reality.

Shock therapy – see electroconvulsive therapy.

Social phobia – extreme insecurity in social situations accompanied by an exaggerated fear of embarrassing oneself.

Sociopathic personality – a behavior pattern that is characterized by disregard for, and violation of, the rights of others and a failure to conform to social norms with respect to lawful behavior.

Stress – a state of arousal that occurs when people encounter events that they perceive as endangering their physical or psychological well-being.

Stress reaction or stress response – reactions to events an individual perceives as endangering his or her well-being. These may include bodily changes as well as psychological reactions such as anxiety, anger and aggression, and apathy and depression.

Stressors – events that an individual perceives as endangering his or her physical or psychological well-being.

Tangential – a word used to describe thoughts or words that are only marginally related to the issue at hand.

Tardive dyskinesia – an involuntary movement disorder or muscular activity that sometimes develops as the result of taking strong antipsychotic medication over a period of time.

Thought disorder – a disorder where associations between ideas are lost or loosened but are not perceived as such by the person.

Tic disorders – childhood disorders characterized by sudden, rapid, recurrent, involuntary motor movements or vocalizations. An example is Tourette's syndrome.

Tourette's syndrome – a childhood disorder characterized by multiple motor tics and one or more vocal tics that causes marked distress or significant impairment in social, academic, or other important areas of function.

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COMMONLY PRESCRIBED PSYCHOTROPIC MEDICATIONS

The medications glossary is intended to help you better understand information you may see in your client's records or medical reports. Lawyers should always consult with medical professionals for a more complete understanding of these medications and their effects and for information about new medications not listed on these pages.

ANTIDEPRESSANTS

Medications used to treat symptoms of depression. Many of these medications are also now considered the medications of choice for anxiety disorders.

Generic Name	Brand Name	Other Uses/Notes
amitriptyline	Elavil, Endep	
amoxapine	Asendin	
bupropion	Wellbutrin	also used to treat ADHD in children
bupropion	Zyban	also used to decrease cigarette smoking in adults
citalopram	Celexa	
clomipramine	Anafranil	also used to treat obsessive-compulsive disorder
desipramine	Norpramin, Pertofrane	also used to treat ADHD and Tic disorders in children
doxepin	Adapin, Sinequan	sometimes used to encourage sleep
fluoxetine	Prozac	approved for use with children. Higher doses used for obsessive-compulsive disorder.
fluvoxamine	Luvox	also used for obsessive-compulsive disorder
imipramine	Janimine, Tofranil	also used to treat in bed-wetting in children
maprotiline	Ludiomil	
mirtazipine	Remeron	
nefazodone	Serzone	
nortriptyline	Aventyl, Pamelor	also used to treat anxiety disorders in children
paroxetine	Paxil	
phenelzine	Nardil	
protriptyline	Triptil, Vivactil	
reboxetine	Edronax	
selegiline	Deprenyl	also used with children to treat ADHD in Tourette's syndrome
sertraline	Zoloft	also used to treat anxiety disorders and obsessive-compulsive disorders in children
tranylcypromine	Parnate	also used to treat ADHD and anxiety disorders in children
trazodone	Desyrel	also used to treat insomnia
trimipramine	Rhotrimine, Surmontil	
venlafaxine	Effexor	

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ANTIANXIETY OR ANTIPANIC

Medications used to treat anxiety, tension, excitation. Many of these medications are classified as benzodiazepines. Many of the antidepressants are also considered to be the medications of choice for anxiety disorders.

Generic Name	Brand Name	Other Uses/Notes
alprazolam	Xanax	
buspirone	Buspar	
chlordiazepoxide	Libritabs, Librium	
clonazepam	Klonopin	
clorazepate	Azene, Tranxene	
diazapam	T-Quil, Valium	
flurazepam	Dalmane	
halazepam	Paxipam	
hydroxyzine	Atarax, Vistaril	
lorazepam	Ativan	
oxazepam	Serax	
prazepam	Centrex	
temazepam	Restoril	

ANTIPSYCHOTIC

Medications used to manage the symptoms of psychotic disorders such as schizophrenia and manic-depressive disorder. Many are used as chemical restraints for aggressive, agitated, and self-abusive behaviors in children and adults. The new generation (atypical) medications tend to have fewer side effects.

Generic Name	Brand Name	Other Uses/Notes
chlorpromazine	Largactil, Thorazine	
chlorprothixene	Taractan	
clozapine	Clozaril	new generation (atypical) medication. Requires weekly blood tests.
fluphenazine	Prolixin, Modecate, Permitil	comes in longer-acting injectable form
haloperidol	Haldol	comes in longer-acting injectable form
loxapine	Loxapac, Loxitane, Daxolin	
mesoridazine	Serentil	
molindone	Lidone, Moban	
olanzapine	Zyprexa	new generation (atypical) medication
perphenazine	Trilafon, Etrafon	
pimozide	Orap	also used to treat Tourette's disorder in children
quetiapine	Seroquel	new generation (atypical) medication
risperidone	Risperdal	new generation (atypical) medication
thioridazine	Mellaril	rarely used any longer
thiothixene	Navane	
trifluoperazine	Stelazine	
triflupromazine	Vesprin	
ziprasidone	Geodon	new generation (atypical) medication

MOOD STABILIZER

Medications used to treat acute manic episodes and to prevent relapse of manic-depressive symptoms. Most of the following except Lithium and olanzapine are also anti-seizure medications.

Generic Name	Brand Name	Other Uses/Notes
carbamazepine	Epitol, Tegretol	also used with children
divalproex Sodium	Depakote, Epival	also used with children
lamotrigine	Lamictal	not for use with children
lithium carbonate (lithium)	Carbolith, Duralith, Eskalith, Lithane, Lithizine, Lithobid, Lithonate, Lithotabs	
lithium citrate	Cibalith-S	also used to treat hyperaggressive behavior in children
olanzapine	Zyprexa	new generation (atypical) medication
valproate (valproic acid)	Depakene, Valrelease	also used with children

ANTIOBSESSIONAL

Medications used to treat symptoms of obsessive-compulsive disorder. They are also used as anti-depressant and anti-anxiety agents.

Generic Name	Brand Name	Other Uses/Notes
clomipramine	Anafranil	
fluoxetine	Prozac	high doses
fluvoxamine	Luvox	

MEDICATIONS USED TO TREAT ADHD (Attention Deficit/Hyperactivity Disorder) IN CHILDREN

Generic Name	Brand Name	Other Uses/Notes
clonidine	Catapres	also used to treat Tourette's disorder, ADHD, aggression, self-abuse, and severe agitation in children
dextroamphetamine	Dexedrine	
dextroamphetamine	Adderall	
guantacine	Tenex	also used to treat Tourette's disorder
methylphenidate	Ritalin	
pemoline	Cylert	
propranolol	Inderal	also used to treat Tourette's disorder, aggression/self abuse, intermittent explosive disorder, and severe agitation in children

ANTI-SIDE EFFECT MEDICATIONS

Medications usually used to treat the neurological side effects of many, especially older anti-psychotic medications. Side effects, also called extrapyramidal symptoms, include tremors and rigidity. Also see ANTI-SEIZURE MEDICATIONS below.

Generic Name	Brand Name	Other Uses/Notes
amantadine	Symmetrel	
benztropine	Cogentin	
propranolol	Inderal	also used to treat some children's behavior disorders
triexyphenidyl	Artane	

ANTI-SEIZURE MEDICATIONS

Medications used to treat side-effects such as seizures. Many are also used to treat bipolar or manic-depressive disorder. Benzodiazepines are often prescribed as anti-seizure medications as well.

Generic Name	Brand Name	Other Uses/Notes
carbamazepine	Epitol, Tegretol	
clonazepam	Klonopin, Rivotril	also used to treat anxiety disorders, psychosis, mania, severe agitation, severe insomnia and Tourette's disorder in children
divalproex sodium	Depakote, Epival	also used to treat bi-polar disorder
ethosuximide	Zarontin	
lamotrigine	Lamictal	also used to treat bi-polar disorder
phenytoin	Dilantin	
primidone	Mysoline	
topiramate	Topamax	
valproate (valproic acid)	Depakene, Valrelease	also used with children

MEDICATIONS USED TO TREAT ALCOHOLISM

Medications used to help people resist drinking.

Generic Name	Brand Name	Other Uses/Notes
calcium carbimide	Temposil	
disulfiram	Antabuse	
naltrexone	ReVia	also used to block the effects of opioides

MEDICATIONS USED TO TREAT INSOMNIA

Medication used to help people sleep better. Some of the benzodiazepines (tranquilizers) are also used to treat insomnia.

Generic Name	Brand Name	Other Uses/Notes
chloral hydrate	Noctec, Somnos, Felsules	
diphenhydramine	Benadryl	also used with children
flurazepam	Dalmane	
oxazepam	Serax	
temazepam	Restoril	
trazodone	Desyrel	also used with children
triazolam	Halcion	
zaleplon	Sonata	
zolpidem	Ambien	

Resources For Help

For training opportunities

Capacity for Justice
3205 South 1st Street
Austin, Texas 78704
(512) 440-0025
Contact: Genevieve Hearon

Mental Health Association of Tarrant County
3136 W. 4th Street
Fort Worth, Texas 76107
(817) 335-5405
Contact: Laura Lee Harris

Texas Criminal Defense Lawyers Association
600 West 13th Street
Austin, Texas 78701
(512) 478-2514
www.tdcla.com

For information about criminal procedure and Texas laws pertaining to persons with mental illness

Staff Attorney Office
Dallas Criminal District Courts
133 N. Industrial Boulevard, 2nd floor, Room A &, LB 7
Dallas, Texas 75207-4313
(214) 653-5724
Contact: Corinne Mason

Texas Criminal Procedure and the Offender with Mental Illness: An Analysis and Guide (2nd ed.,1999)
Professors Brian Shannon and Daniel Benson
Texas Tech University School of Law
Single free copies available from NAMI-Texas (512) 374-9355

Other helpful organizations

Texas Council for Offenders with Mental Impairments
8610 Shoal Creek
Austin, Texas 78757
(512) 406-5406
Contact: Dee Kifowit

NAMI Texas
3710 Cedar Street Box #23, Suite 229
Austin, Texas 78705
(512) 374-9339
namitexas@ texami.org
Contact: Joe Lovelace

Mental Health Association in Texas
8401 Shoal Creek Blvd.
Austin, Texas 78757
(512) 454-3706
Contact: Kim McPherson or Melanie Gantt

The Arc of Texas
(for information about mental retardation)
1600 W. 38th Street, Suite 200
Austin, Texas 78731
(512) 454-6694
thearcoftexas.org

Texas Defender Service
510 South Congress, Suite 307
Austin, Texas 78704
(512) 320-8300
www.texasdefender.org
Contact: John Niland

Advocacy Inc.
7800 Shoal Creek Blvd. #171-E
Austin 78757
(512) 454-4816
www.advocacyinc.org

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